February 10, 2009

Dova Romelus
Division of Health Care Finance & Policy
Two Boylston St., 5th Floor
Boston, MA 02116

Dear Ms. Romelus:

I am writing in response to a meeting notice passed on to me by the CFO and Senior Vice President of Northeast Health Systems (see attached). I was unable to attend the February 3rd meeting, but do wish to provide some comments in writing to you.

As a preface to my comments, please be aware that the organization that I am the Executive Director of was affiliated with Partners Community Health Plan (PCHI) from 2000 to YE 2006. Currently, and since 2007, the Northeast PHO is an independent Physician Hospital Organization (PHO), non-affiliated with any major network and jointly owned by a Physician Organization (New England Community Medical Group) and Northeast Health Systems. My comments are as follows:

- From 1990-2000, the major health plans of Massachusetts had substantial market penetration and power. Throughout that decade they kept physicians' payments flat with no increase. That was the background for the discussions between Partners and BCBSMA.
- The Commonwealth has the distinction of having a very high cost of living including, but not limited to, the cost of housing.
- As a result of this market power, the fees paid to physicians (practicing in Massachusetts during this decade) were below the rest of the country when taken at face value. When the cost of living in MA, and the related cost of financing and managing a practice and employing staff in MA were included, the payment rates were not sufficient to support most practices, especially Primary Care Practices.
- Recruitment of physicians to practice in Massachusetts became almost impossible and is still difficult. Salaries offered in other parts of the country are higher and the cost of living lower.
- Physicians are being encouraged to adopt new technology in their practices. The cost of purchasing and implementing an Electronic Medical or Health Record (EMR/EHR) is borne with few exceptions by the provider and/or the health system with which the practice is affiliated. Eighty-eight (88%) of the PHO's Primary providers and 66% of PHO Specialties have paid for and implemented this technology.

- Hospitals are likewise required to adopt new technology that increases patient safety, such as Computerized Provider Order Entry (CPOE), Smart Pumps, and bar coding of pharmaceuticals. No one disagrees with the goals and the need to improve patient safety; however, there is no increase in payment to support the purchase or the resources needed to implement the technology.
- Hospital margins in Massachusetts are very thin.
- The major HMOs in Massachusetts are among the highest quality providers nationally and have very high levels of consumer satisfaction. This is a result of provider (physician and hospital) performance, provider affiliations with health plans, as well as the quality of health plan administration. Do not throw the baby out with the bath water as you seek to lower costs.
- The Alternative Quality Contract (AQC) model offered by Blue Cross Blue Shield of Massachusetts is a global capitation model which removes the risk of the cost of care from the insurer and puts that risk entirely onto the providers. The majority of providers do not have sufficient reserves or infrastructure to take on the risk of this payment form without considerably more investment. Forcing this on providers will be a disaster for consumers as well as providers. Only a small portion of the contract relates to Quality Care.
- The health plans do not provide cost data to providers unless they have assumed full risk for their population. Therefore, the majority of providers do not have the comparative data to be able to determine where excess costs are, and how to wring costs and utilization out of the system.
- Excess costs in the health care system can be better controlled via technology implementation coupled with the right incentives. Paying providers less is not the correct solution. Rather incentives in the form of shared savings for reducing costs make far more sense, as well as requiring transparency of data and costs by the health plans.
- The migration of well financed Academic Medical and Tertiary Centers into the community marketplace creates an unfair competitive model and will only serve to increase capital spending and the cost of actual care delivery, in addition to duplicating services and technology.
- Academic/Tertiary Medical Centers are paid more to care for complex, very sick patients, and that is as it should be. They should not be paid more than the community providers to provide the same secondary services in a community setting that are currently being provided by local provider systems located within that community.
- The Commonwealth must be careful that whatever cost control methodology it adopts, it does not reduce the current quality of care provided. The model should:
    - Ensure that a sufficient volume of cases are available to be able to demonstrate cause and effect in the analysis. For example, in the GIC tiering of specialists, the vast majority of specialists default to the middle tier due to the insufficient of data in the treatment groups the GIC has

chosen; the tier is not based on performance. Also, each health plan uses it's own data and benchmarks versus MHQP or Mercer data which are more valid and robust.
    - Recognize that the goal needs to be to improve systems of care and therefore evaluate providers' performance in aggregate to demonstrate improved quality and lowered costs
    - Focus of change needs to be system and population-based and not the individual provider and individual patient
    - Avoid penalizing small independent provider systems while rewarding larger employed physician systems. Improvements over baseline should be the goal and goals reset in reasonable timeframes.

- Consumers need to have responsibility for controlling health care costs either through education, incentives or benefit design. However, the Commonwealth needs to realize that large deductibles result in more bad debt for providers.
- The Commonwealth of Massachusetts has legislated a large number of mandates to be included in health insurance plans offered in Massachusetts. Removing or modifying these, as well as some of the other benefit design requirements in MA, would be a good place to begin the evaluation process for lowering costs.

Thank you for taking the time to review my thoughts.

Sincerely,

Jeanne M. Holland
Executive Director

JMH/ss